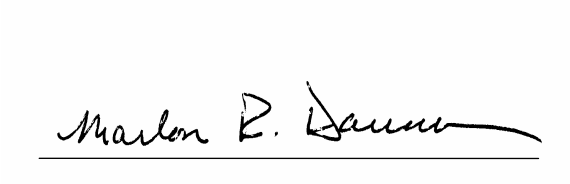
PREFERRED PLUS OF KANSAS

CERTIFICATE OF COVERAGE

STATE OF KANSAS

This certifies the Subscriber and the Dependents enrolled hereunder are entitled to Covered Services in accordance with the terms, conditions and provisions of this Certificate. This Certificate will be guaranteed renewable and cannot be canceled by Preferred Plus of Kansas, Inc., except for those situations referenced in the Termination provisions of the Group Contract.

Preferred Plus of Kansas, Inc.
Marlon R. Dauner
President



Corporate Office:
8535 E. 21st Street North
Wichita, Kansas 67206
316-609-2390 or 1-800-660-8114

an affiliated company of Preferred Health Systems

PPK-42 GS FP 1/05

Edition 1/07

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Attachment–Schedule Of Benefits

SECTION 1 - DEFINITIONS

ALLOWED AMOUNT(S) means the maximum monetary amount Contracting Providers agree to accept for Health Care Services rendered to Members when provided, prescribed or directed by a PCP, and/or authorized by PPK.

ALTERNATE RECIPIENT means any child of a Subscriber who is recognized by the plan under a medical child support order, which is made pursuant to Kansas domestic relations law or section 1908 of the Social Security Act and any amendments therein as having a right to enrollment in PPK as on file with the Group.

BENEFIT PERIOD means the time interval (typically twelve (12) months) during which certain Allowed Amount(s) for Covered Services are accumulated for purposes of determining Coverage provisions such as, but not limited to, satisfaction of out-of-pocket maximums and benefit limits. Refer to your Schedule of Benefits to determine the Benefit Period applicable to your Plan.

BIOLOGICALLY BASED MENTAL ILLNESS means behavioral health illnesses with the following diagnoses: schizophrenia; schizo affective disorder; schizophreniform disorder; brief reactive psychosis; paranoid or delusional disorder; atypical psychosis; major affective disorder (bipolar and major depression); cyclothymic and dysthymic disorder; obsessive compulsive disorder; panic disorder; pervasive development disorder, including autism, attention deficit disorder and attention deficit hyperactive disorder.

CERTIFICATE *or* CERTIFICATE OF COVERAGE means a written description setting forth the essential features of and benefits to which a Member is entitled, including exclusions, limitations on benefits and requirements to receive benefits.

CLAIM FOR BENEFITS *or* CLAIM(S) means a request for a service or payment of a service made by a Member in accordance with PPK's procedure for filing Claims. A Claim includes Urgent Care Claims, Pre-Service Claims and Post-Service Claims. A Claim must have sufficient information upon which to base a decision regarding benefits according to all of the provisions of this Certificate.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1986. This federal law requires employers with group health plans to offer participants and beneficiaries the opportunity to purchase the continuation of health care coverage for a limited period of time after the occurrence of a qualifying event, which is usually the termination of employment. The law applies to private employers with twenty (20) or more employees.

COINSURANCE means a portion of the Allowed Amount payable by a Member, usually based on a percentage of the Allowed Amount for Covered Services under the terms of the Plan.

CONTRACTING PROVIDER DIRECTORY means a listing of Providers that have contractually agreed to render services to Members. The Provider list is subject to change without notice and Providers presently contracting cannot be guaranteed to be available in the future.

CONTRACTING PROVIDERS mean Physicians, Health Professionals, Facilities, and Hospitals which or who have entered into agreements, directly or indirectly, with Kansas Health Plan ("KHP") to provide Health Care Services to Members.

COPAYMENT means a fixed monetary amount that is payable by the Member each time specified Covered Services are received.

COVERAGE means the benefits provided under the Certificate for Covered Services rendered to Members, subject to the terms, conditions, exclusions, and limitations of the Certificate.

COVERED SERVICES are Medically Necessary Health Care Services, per the definitions herein, provided to Members pursuant to the benefits of this Certificate.

DEPENDENT means the spouse or child of a Subscriber as defined by the Group.

EMERGENCY *or* EMERGENCY MEDICAL CONDITION is an illness or injury manifesting itself by acute symptoms of such severity that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

EMERGENCY SERVICES mean ambulance services and other Health Care Services rendered or required to evaluate and treat an Emergency Medical Condition, as directed or ordered by a Physician.

ENROLLMENT AREA is where employees must reside to be eligible to enroll in PPK.

EXPERIMENTAL *or* INVESTIGATIONAL means a drug, device, medical treatment or procedure that meets any of the following:

1. The drug or device cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
2. The informed consent document utilized with the drug, device, treatment or procedure indicates that such drug, device, medical treatment or procedure is experimental/investigational;
3. Reliable evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is in the research, experimental, study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
4. Reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature.

FACILITY(IES) mean an entity licensed, certified, registered, or approved by the proper authority of the state in which it is located. Facilities include, but are not limited to, ambulatory surgery centers, skilled nursing facilities, home health agencies, durable medical equipment Providers, residential treatment centers, mental health/substance abuse facilities, independent laboratories, hospice, and renal treatment centers.

GRACE PERIOD means the thirty-one (31) days immediately following the last day of the preceding Coverage month. If the Grace Period expires on a weekend, the Grace Period will be extended to the first business day thereafter.

GROUP means the State of Kansas.

GROUP CONTRACT means an agreement between a Group and PPK to provide benefits for selected Health Care Services (Covered Services) which by its terms specifies eligibility. The Group Contract is inclusive of the Certificate and the Application, and is a contract for insurance benefits in its entirety.

GROUP EFFECTIVE DATE is the date set forth in a Group Contract that specifies when the terms of the agreement will take effect. Upon renewal of a Group Contract, a new Group Contract and new Group Effective Date shall result.

HEALTH CARE SERVICE(S) means a service or item (intervention) provided by a Physician, Health Professional, Hospital, or Facility that is intended primarily to prevent, diagnose, treat, or palliate a disease, illness or injury, genetic or congenital defect, pregnancy, or psychological condition that lies outside the normal, age appropriate human variation.

HEALTH PROFESSIONALS mean dentists, nurses, podiatrists, optometrists, physician assistants, physical therapists, psychologists, social workers, dieticians, occupational therapists, chiropractors and other professionals engaged in the delivery of Health Care Services who are licensed or registered, and practice under authority of the appropriate state laws. Such Health Professionals must be acting within the scope of their license or registration; and be qualified to provide Health Care Services.

HIPAA means the Health Insurance Portability and Accountability Act of 1996 and its administrative regulations.

HOSPITAL means an institution or Facility licensed, approved, certified or recognized by the proper authority of the state in which it is located; and is designated as “general” or “specialty” based on its hours of operation for selected Health Care Services and length of stays permitted, is operated for medical treatment of sick and/or injured persons as inpatients and has nursing services available during all hours of operation.

IDENTIFICATION CARD means a written document that identifies an individual as a Member of PPK.

KANSAS HEALTH PLAN (KHP) is a Kansas Corporation and network of Contracting Providers utilized by PPK. KHP is a wholly owned subsidiary of Preferred Health Systems.

MEDICAL NECESSITY *or* MEDICALLY NECESSARY means a service or item (intervention) provided by a Physician, Health Professional, Hospital, or Facility that is intended primarily to prevent, diagnose, treat or palliate a disease, illness or injury, genetic or congenital defect, pregnancy, or psychological condition that lies outside the range of normal, age appropriate human variation.

Interventions must be:

1. Effective for the Member's medical condition and indications, which is determined by scientific evidence consisting primarily of controlled clinical trials that demonstrate the effect of the intervention on health outcomes. If clinical trials have not been conducted, effectiveness is evaluated on the basis of professional standards of care or expert opinion.
2. Expected to produce the intended results and have expected outcomes that outweigh potential harmful effects.
3. Measurable by positive changes in the Member's health status as determined by length or quality of life.
4. Appropriate for the Member's medical condition and indications. The benefits relative to cost must represent an economically efficient use of resources.
5. Performed in the proper setting, at the proper time, in the proper amounts, and by the proper Provider of care relative to the Member's condition.
6. Recommended by the PCP and/or treating physician and determined by PPK's medical director to meet the above criteria.

MEMBER means a Subscriber or Dependent enrolled in PPK named on the Identification Card. If a Member is eligible for Medicare benefits and Medicare is the primary payor for the Member's coverage as specified by the applicable law, the Member must be enrolled in Medicare Part A (hospital) and Part B (medical).

MEMBER(S) EFFECTIVE DATE is the date set forth by the Group that specifies when Coverage will take effect, in accordance with the Certificate.

NON-CONTRACTING PROVIDER(S) mean Physicians, Health Professionals, Facilities, and Hospitals which or who have not entered into a contract with KHP, PPK or designated affiliates to provide Health Care Services to Members.

NON-COVERED SERVICE(S) mean Health Care Services that are exclusions or limitations of benefits as identified in the Certificate and Schedule of Benefits.

OPEN ENROLLMENT PERIOD means a period, defined by the Group, during which Subscribers and their Dependents may enroll in PPK.

PHYSICIAN means a person licensed to practice medicine and/or surgery under the Kansas Healing Arts Act or under the authority of similar state laws. Such Physician must be acting within the scope of his or her license or registration and be qualified to provide Health Care Services.

PREFERRED PLUS OF KANSAS, INC. (PPK) is a Kansas health maintenance organization that provides insurance benefits as authorized by state law. PPK is a wholly owned subsidiary of Preferred Health Systems.

PRIMARY CARE PHYSICIAN (PCP) means a Physician who has agreed to provide and coordinate the medical care of a member. Primary Care Physicians may include family practitioners, general practitioners, internists, and pediatricians.

PRIOR AUTHORIZATION is the process defined by PPK of obtaining approval for receiving specific Health Care Services prior to those services being rendered. The process includes determination of eligibility, Covered Services, and Medical Necessity as well as implications about the use of Contracting and Non-Contracting Providers.

PROVIDER means Physicians, Health Professionals, Facilities, and Hospitals that are licensed, registered, or certified by appropriate state authorities to provide Health Care Services to the general public in accordance with the scope of their license, registration, or certification and who are qualified to provide those Health Care Services.

REFERRAL AUTHORIZATION means the process defined by PPK of obtaining approval of a PCP to receive specific Health Care Services of a Specialist Physician, Health Professional, Facility or Hospital prior to seeking such Health Care Services.

SCHEDULE OF BENEFITS means the document that summarizes benefits and includes, but is not limited to, cost sharing amounts and limitations.

SERVICE AREA means the geographic boundaries in which PPK is authorized to transact business.

SPECIAL DEPENDENT ENROLLMENT PERIOD means the thirty-one (31) day period in which Subscribers are allowed to enroll newly acquired dependents as a result of marriage, birth, adoption, or placement in the home for adoption or filing for legal guardianship. All enrollment changes have to be submitted to the Group.

SPECIALIST PHYSICIAN means a Physician who has contracted with PPK to provide certain services to Members upon referral by a Primary Care Physician.

SUBSCRIBER means a Member of a Group who meets the Eligibility requirements as specified in this Certificate of Coverage or Group Contract.

WAITING PERIOD means a time interval as defined by the Group starting from the Employee's date of hire to the Member's Effective Date.

SECTION 2 - BASIC PROVISIONS

1. ELIGIBILITY

As defined by the Group.

2. ENROLLMENT

2.1 A person who meets the Eligibility Section requirements of this Certificate of Coverage may enroll by submitting a completed application form to the Group within thirty-one (31) days of the date of eligibility. A person who is a Late Enrollee will not be permitted to enroll until the next Open Enrollment Period.

2.2 A Late Enrollee is an individual who qualifies for eligibility under the Certificate and who applies for coverage more than thirty-one (31) days after becoming Eligible for Coverage. An individual is not a Late Enrollee if the individual:

- Was covered under another group policy which provided hospital, medical or surgical expense benefits or was covered under section 607(1) of the Employee Retirement Income Security Act of 1974 (ERISA) at the time the individual was eligible to enroll; and
- States in writing, at the time of Open Enrollment, that coverage under another group policy which provided hospital, medical or surgical expense benefits was the reason for declining enrollment, but only if the Group or PPK required such a written statement and provided the individual with notice of the requirement for such written statement and the consequences of such written statement; and
- Has lost coverage under another group policy providing hospital, medical or surgical expense benefits or under section 607(1) of the Employee Retirement Income Security Act of 1974 (ERISA) as a result of the termination of employment, reduction in the number of hours of employment, termination of employer contributions toward such coverage, the termination of the other policy's coverage, death of a spouse, divorce, legal separation or was covered under a COBRA continuation provision and the coverage under such provisions was exhausted; and
- Requests enrollment within thirty-one (31) days after the termination of coverage under the other policy; or
- A court has ordered coverage to be provided for an eligible spouse or minor child under a Member's policy.

2.3 A Special Dependent Enrollment Period of thirty-one (31) days will occur for Dependents due to marriage, birth, adoption, placement for adoption, filing for legal guardianship or other events as defined by the Group.

- Special dependent enrollment shall include enrollment for a natural newborn child of a Subscriber, a newborn child for whom the Subscriber is the legal guardian, an adopted newborn child of the Subscriber, adopted child of the Subscriber or a child placed in the Subscriber's home for adoption.
- If the Subscriber's coverage type is employee only, the newborn or adopted child or the child for whom the Subscriber has legal guardianship does not have automatic coverage. <u>In order for the child to be effective as stated in the Effective Dates of Coverage, Article IV, the Subscriber must enroll the child through the Group within thirty-one (31) days of birth, adoption, filing for legal guardianship, or placement for adoption.</u> If the child is born, adopted, or placed for legal guardianship or adoption on or before the 15th day of the month, an additional premium will be charged for the entire month. However, if the birth, adoption or placement for adoption or legal guardianship occurs on or after the 16th day of the month, no additional premium will be charged for that month.
- <u>If the Subscriber's coverage type is employee/dependent, the newborn or adopted child or child for whom the Subscriber has legal guardianship is automatically covered for thirty-one (31) days.</u> In order for the child to be covered beyond the 31st day, the Subscriber must enroll the child through the Group within thirty-one (31) days of birth, adoption, filing for legal guardianship, or placement for adoption. If applicable, a premium adjustment will occur from the 32nd day.

2.4 An employee of a Group and their Dependents who fail to enroll during the Special Dependent Enrollment Period or the Open Enrollment Period will not be permitted to enroll until the next Open Enrollment Period.

2.5 If a Dependent is eligible for Coverage under a Qualified Medical Child Support Order (QMCSO), Coverage will be effective on the earlier of the date designated in the QMCSO or the date on which PPK qualifies the order. The Group and PPK, pursuant to specifications of federal and state law, must qualify Medical Child Support Orders. The procedures for qualification require the Subscriber to timely submit the Medical Child Support Order to the Group for initial qualification or rejection. The Group will forward the order to PPK for qualification or rejection. PPK shall provide notice of the decision to all parties identified in the order. If the order is qualified, an identification card and Certificate of Coverage will be issued to the Alternative Recipient.

3. ELIGIBILITY DATES

The following eligibility dates are applicable to Members:

3.1 Any person meeting the Eligibility Section requirements, on the effective date of this Certificate of Coverage will become eligible on such date.

3.2 Natural and adopted newborn children will be treated as Dependents from birth if enrolled within thirty-one (31) days from the date of birth as outlined in the Enrollment Section.

3.3 Children for whom the Subscriber is the legal guardian will be covered from the date of filing of legal guardianship documents, if enrolled within thirty-one (31) days from such filing as outlined in the Enrollment Section.

3.4 Children placed in the Subscriber's home for adoption will be treated as Dependents from the date of placement in the home if enrolled within thirty-one (31) days from such placement as outlined in the Enrollment Section.

4. EFFECTIVE DATES OF COVERAGE

Coverage will become effective on one (1) of the following dates as applicable:

4.1 Effective Dates of Coverage-Employees and Dependents

- When a person makes written application on or prior to their eligibility date, Coverage will begin on the eligibility date.
- When a person makes written application after the eligibility date, Coverage will begin on the date specified by the Group.
- When a person makes written application for membership during an Open Enrollment Period, Coverage will begin on the first day of the calendar month as stated on the face page of the Group Contract.

4.2 Effective Dates of Coverage-New Acquired Dependents

If properly enrolled as outlined in 2.1 and 2.3 of the Enrollment section, Coverage will begin on:

- In the case of marriage, the date specified by the Group. Other newly acquired dependents as a result of a marriage, if properly enrolled, may be effective at this time.
- In the case of a natural newborn, adopted newborn child, or newborn for whom the Subscriber is the legal guardian, the date of birth, the date of filing the legal guardianship documents, the date the petition for adoption is filed, or from the date the child was placed in the Subscriber's home for adoption. The employee and/or spouse, if properly enrolled, may be effective on the same date of such child.
- In the case of a child other than a newborn, the date the petition for adoption is filed, the date the child is placed in the Subscriber's home for adoption or the date the Subscriber files for legal guardianship. The employee and/or spouse, if properly enrolled, may be effective on the same date of such child.

5. TERMINATION OF COVERAGE

5.1 Coverage for a PPK Member will terminate in the following circumstances:

- If a Member ceases to meet the Eligibility Section requirements, Coverage will terminate upon the date specified by the Group, subject to the Continuation of Coverage/Conversion Section in this Certificate of Coverage.
- If this Certificate of Coverage terminates in accordance with the Termination provisions of the Group Contract, Coverage will terminate the day following the last effective date of this Certificate of Coverage.
- If a Member selects alternative coverage in a health benefit plan offered by Group, Coverage will terminate on the first effective day of such other alternative coverage.
- In the event of the Subscriber's death, Coverage for Dependents will terminate on the last day of the period for which payments have been made by or on behalf of the Subscriber, subject to the Continuation of Coverage/Conversion Section of this Certificate of Coverage.

5.2 Coverage for a PPK Member may terminate in the following circumstances:

- If a Member fails to make Copayments required under the Schedule of Benefits, Exclusions and Limitations, Coverage may terminate for the Member upon thirty-one (31) days written notice. Termination shall apply to Subscriber and Dependents concurrently.

- If a Subscriber permits the use of their or their dependent's PPK identification card by any unauthorized person, or makes unauthorized use of another person's PPK (or any of its affiliates) identification card, all covered Members under the Subscriber's Coverage may be terminated immediately upon written notice by PPK. If any Member permits the use of PPK identification card by any unauthorized person, or makes unauthorized use of another person's PPK (or any of its affiliates) identification card, Coverage of such Member under this Certificate may terminate immediately upon written notice by PPK.
- If a Member engages in gross misbehavior, fraud or the making of intentional misrepresentation of material fact toward participating Providers and/or PPK personnel in applying for or seeking any benefits under PPK or any of its affiliates, Coverage under this Certificate may terminate immediately upon written notice by PPK.

5.3 Any monthly payments received on the Member's behalf for coverage beyond the effective date of termination will be refunded by PPK. In addition, the Member will be responsible for reimbursement of any services covered by PPK after the effective date of such Member's termination.

6. EXTENSION OF BENEFITS

A Member's Coverage ends on the date of cancellation, except for a Member(s) who is receiving inpatient hospital services when the Coverage terminates. If a Member is receiving inpatient hospital services when the Coverage ceases and has remained hospitalized as an inpatient from the date Coverage ceases to the date this benefit would be payable, PPK will pay for Covered Services relating to such inpatient hospitalization. This benefit will not be payable after inpatient hospitalization ceased, or for more than thirty-one (31) days after Coverage ceases. No premium is required during the period this benefit is payable.

7. RELATIONSHIP OF CONTRACTING PARTIES

7.1. The relationship between PPK and Contracting Providers is an independent contractor relationship. Contracting Providers are not employees or agents of PPK, nor is PPK or any PPK employee considered to be either an employee or agent of any Contracting Provider.

7.2. Neither the Group nor any person enrolled in PPK through the Group is the agent or representative of PPK, and neither will be liable for any acts or omissions of PPK, its agents, employees, Contracting Providers or any other person, agency or organization with which PPK has made or hereafter will make arrangements to perform Covered Services under this Certificate of Coverage.

8. PHYSICIAN-PATIENT RELATIONSHIP

8.1 Each Member will, at time of enrollment in PPK, select a Primary Care Physician from PPK's Contracting Provider Directory.

8.2 The Primary Care Physician will maintain a physician-patient relationship with the Member and will be responsible for providing, prescribing, or directing all Covered Services except those services that do not require Primary Care Physician approval as described in the Plan Provisions.

8.3 The Member will look to the Primary Care Physician to direct their care and accept procedures and/or treatment recommended by the Primary Care Physician.

8.4 A Member may, for personal reasons, refuse to accept procedures and/or treatment recommended by the Primary Care Physician. Said Physician may regard such refusal as incompatible to preservation and continuation of the physician-patient relationship, obstructive to the provision of proper medical care and detrimental to the Member's general health and welfare. If the Member refuses to accept recommended procedures and/or treatment and the Primary Care Physician believes no professionally acceptable alternatives exist, such Member will be so advised. If the Member still refuses, neither the Primary Care Physician, other Contracting Provider nor PPK will have further responsibility to provide for the condition under treatment.

8.5 It is recognized that instances may occur where the Primary Care Physician, for good cause, finds it impossible to establish an appropriate and viable physician-patient relationship with the Member. Such Physician may petition PPK in writing to require the Member to select another Primary Care Physician. The petition must outline in detail failed attempts of the Primary Care Physician to establish a working physician-patient relationship. If PPK agrees to accept the petition, the Member will be notified in writing of PPK's decision and will be given ten (10) working days to select another PPK Primary Care Physician.

8.6 The Member may request transfer of care to another Primary Care Physician whose practice is open to PPK Members. Transfer of care to the newly selected Primary Care Physician will be effective the first of the month following PPK's date of receiving the request.

8.7 If the agreement between the Primary Care Physician and PPK is terminated for any reason, PPK will provide notice to the Member and assist the Member in selecting another Primary Care Physician whose practice is open to PPK Members. PPK will provide continuation of care to Members up to ninety (90) days by a Provider who is terminated from the

network in those cases where such continuation of care is Medically Necessary and in accordance with the dictates of medical prudence and where the Member has special circumstances such as a disability, a life-threatening condition or is in the third trimester of pregnancy. The Member will not be liable to the Provider for any amounts owed for medical care other than Copayments and Coinsurance as specified in the Schedule of Benefits.

9. CONTINUATION OF COVERAGE/CONVERSION

9.1 CONTINUATION OF COVERAGE UNDER COBRA

There is a federal law which permits persons to continue coverage under an employer group health plan. This law is referred to as COBRA, which stands for the "Consolidated Omnibus Budget Reconciliation Act of 1986" and amendments thereto. The law applies to employers of twenty (20) or more employees, not to insurance carriers. If your employer changes from Preferred Plus of Kansas, Inc. to another insurance carrier or third party administrator (in the case of a self-funded arrangement), the right to continuation under this federal law transfers to the new carrier or to Claims adjudication under the new administrator.

PPK has agreed with the employer to undertake only limited duties with respect to COBRA as set forth below:

Enrollment and Benefit Changes

- If the Group changes benefits, the COBRA Members' benefits will also change to match the Group's new benefit package.
- If the employer changes insurers during the period of continued Group benefits, the COBRA Members for that Group will be canceled under this Certificate and become the responsibility of the new insurer.

Conversion Privilege under COBRA

- COBRA Members who complete the COBRA continuation of benefits period are then eligible for a conversion contract at the conversion rates then in effect.
- This conversion is only applicable to Members whose Group offers Coverage with Preferred Plus of Kansas, Inc., at the time the Member's eligibility under COBRA ends.
- PPK will give the Member the notice of conversion rights at least thirty (30) days prior to the termination of COBRA continued benefits.
- Please refer to 9.4 CONVERSION for details regarding the conversion privilege.

9.2 CONTINUATION OF COVERAGE UNDER USERRA

There is a federal law which permits persons to continue coverage under an employer group health plan if their coverage is terminated due to service in the military. This law is referred to as USERRA, which stands for the "Uniformed Services Employment and Reemployment Rights Act of 1994" and amendments thereto. The law applies to employers, not to insurance carriers. If your employer changes from Preferred Plus of Kansas, Inc. to another insurance carrier or third party administrator (in the case of a self-funded arrangement), the right to continuation under this federal law transfers to the new carrier or to Claims adjudication under the new administrator.

PPK has agreed with the employer to undertake only limited duties with respect to USERRA as set forth below:

Enrollment and Benefit Changes

- If the Group changes benefits, the USERRA Members' benefits will also change to match the Group's new benefit package.
- If the employer changes insurers during the period of continued Group benefits, the USERRA Members for that Group will be canceled under this Certificate and become the responsibility of the new insurer.

Failure to Apply for Reemployment

Following completion of the Member's military service, the Member's right to continue coverage under USERRA shall end if the Member does not apply for reemployment within the applicable time period set forth in USERRA (43 U.S.C. § 4312(c)).

Conversion Privilege under USERRA

- USERRA Members who complete the USERRA continuation of benefits period are then eligible for a conversion contract at the conversion rates then in effect.
- This conversion is only applicable to Members whose Group offers Coverage with Preferred Plus of Kansas, Inc., at the time the Member's eligibility under USERRA ends.
- PPK will give the Member the notice of conversion rights at least thirty (30) days prior to the termination of USERRA continued benefits.
- Please refer to 9.4 CONVERSION for details regarding the conversion privilege.

9.3 KANSAS CONTINUATION OF COVERAGE

If the Member is not entitled to COBRA or USERRA and Coverage under this Certificate terminates for any reason, the Member may continue such Coverage if the Member has been insured under this Certificate, or any other group policy providing similar benefits which it replaced for at least three (3) months immediately prior to termination of Coverage under this Certificate. If the Member wishes to continue coverage he/she may do so by submitting a completed application to PPK within thirty-one (31) days after termination of this Coverage or receipt of notice of continuation rights from PPK, whichever is later.

The continued Coverage will terminate on the earliest of:

- six (6) months after the date the continued Coverage began;
- the end of the period for which Coverage was in effect if the Member fails to make their premium payment before the end of the Grace Period;
- the premium due date following the date the Member is or could be covered by Medicare; or
- the date coverage under another similar plan is obtained.

9.4 CONVERSION

If the Group Contract covering any Member terminates for any reason and the Member has been covered by this Certificate for at least three (3) consecutive months and continues to reside in the Service Area, he/she may change to a conversion policy by submitting a completed conversion application to PPK, and the required premium payments within thirty-one (31) days after termination of the Group Contract, or receipt of notice of conversion rights from PPK, whichever is later. The conversion policy does not require evidence of insurability of the person to be covered.

Conversion notices will be mailed to:

- The Subscriber named on the Identification Card at such Subscriber's latest address as it appears on PPK records; and
- Dependents who cease to be eligible at such Dependent's address provided to PPK when PPK is notified that such person is no longer an eligible Dependent.

Application for conversion must be received by PPK within thirty-one (31) days after termination of Coverage or receipt of notice of conversion rights from PPK, whichever is later.

Failure to apply within these thirty-one (31) days and pay the required premium payments to PPK will void the conversion privilege.

PPK will give the Member notice of the conversion right at least once during the Kansas Continuation of Coverage six (6) month period.

9.5 KANSAS CONTINUATION AND CONVERSION COVERAGE EXCEPTIONS

Kansas Continuation Coverage and Conversion Coverage are not available to a Member if:

- the Member failed to pay any required premium after receiving reasonable notice of such required premium from PPK.
- the discontinued PPK Group Contract is replaced by similar group coverage within thirty-one (31) days;
- the Member is or could be covered by Medicare or any other insured or non-insured arrangement, which provides hospital, surgical or medical coverage and benefits for individuals in a group under which the person was not covered prior to such termination; or
- the Member is terminated for gross misbehavior, fraud, or the making of intentional misrepresentation toward PPK personnel in applying for or seeking any benefits under PPK (or any of its affiliates).

10. COMPLAINTS AND GRIEVANCES

If a Member wishes to express a concern about PPK's operation or Contracting Providers, the Member may do so by submitting a verbal complaint or written grievance. A complaint is a verbal expression of dissatisfaction regarding PPK's operation or Contracting Providers. To express a complaint, please contact Member Services at 316-609-2390 or 1-800-660-8114 (outside of Wichita). Members may submit a grievance by:

- writing PPK at 8535 E. 21st Street North, Wichita, Kansas 67206 to the attention of the Member Services Department; or
- sending a fax to 316-609-2327; or
- sending an e-mail to phsimail@phsystems.com.

All grievances will be responded to in writing by PPK.

11. CLAIMS AND APPEAL PROCEDURES

This section outlines the procedures and time frames applicable to Claims decisions and Appeal decisions for Urgent Care Claims, Pre-Service Claims, and Post-Service Claims. It is the policy of PPK to provide Members a full and fair review of Claims decisions and Appeal decisions.

11.1 DEFINITIONS

For the purposes of this section, the following terms and their definitions will apply:

Adverse Decision means a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Member's eligibility to participate in PPK. The term shall include a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate. Adverse Decision, for the purposes of External Review procedures, is limited to the Claims identified in the definition of Claim Eligible for External Review.

Appeal means a written request for reconsideration of a decision made by PPK on a Claim or a written or verbal request for reconsideration of a decision made by PPK on an Urgent Care Claim.

Authorized Representative for non-Urgent Care, shall mean the following: (i) an immediate family member of the Member; (ii) a health care Provider who is a participating Provider in PPK and who has or had a treatment relationship with the Member; and/or (iii) a non-participating health care Provider or other individual identified by the Member on an Appointment of Representative Statement. For Urgent Care, such written authorization is not required if the Appeal is made on the Member's behalf by a health care Provider with knowledge of the Member's medical condition even if such Provider is not a participating Provider.

Claim for Benefits or Claim(s) means a request for a service or payment of a service made by a Member in accordance with PPK's procedure for filing Claims. A Claim includes Urgent Care Claims, Pre-Service Claims and Post-Service Claims. A Claim must have sufficient information upon which to base a decision regarding benefits according to all of the provisions of this Certificate.

Claim Eligible for External Review means (1) in the case other than an Emergency Medical Condition, a Claim for a proposed or delivered health care service which would otherwise be covered under this Certificate but for which the Member has received an Adverse Decision following a second level Appeal due to the fact that the service is not or was not Medically Necessary, or the health care treatment has been determined by PPK to be Experimental or Investigational, and the denial leaves the Member with a financial obligation or prevents the Member from receiving the requested services, or (2) in case of an Emergency Medical Condition, a Claim for which an initial Adverse Decision by PPK that a proposed health care service, which would otherwise be covered under this Certificate, is not Medically Necessary or the health care treatment has been determined by PPK to be Experimental or Investigational and the denial would leave the Member with a financial obligation or prevent the Member from receiving the requested service.

Expedited Appeal means an Appeal that may be requested either orally or in writing if the Member feels his condition requires Urgent Care.

External Review means the review of an Adverse Decision by an external review organization, which conducts independent External Reviews of Adverse Decisions pursuant to a contract with the Kansas Insurance Department.

Pre-Service Claim means a request for a Claims decision when Prior Authorization of the Covered Service is required by PPK, unless the Claim involves Urgent Care. Requests for advance information of PPK's possible coverage of items or services or advance approval of Covered Services where such approval is not required by this Certificate do not constitute Pre-Service Claims unless the Member requests the name of a Contracting Provider and there is not a Contracting Provider in the network who can perform the requested service. For example, if a Member requests advance approval of a service and PPK cannot offer the Member the name of one (1) or more Contracting Providers who could perform the service, such inquiry would be considered a Pre-Service Claim.

Post-Service Claim means a request for a Claims decision for items or services that have been provided.

Urgent Care means care for a condition when a delay in receiving such care could seriously jeopardize the life or health of the Member or the ability of a Member to regain maximum function or, in the opinion of a Physician with knowledge of the Member's condition, would subject the Member to severe pain that could not be adequately managed without care or treatment. In determining whether a Claim involves Urgent Care, PPK must apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, if a Physician with knowledge of the Member's medical condition determines a Claim involves Urgent Care, the Claim must be treated as an Urgent Care Claim.

Urgent Care Claim means a request for a Claims decision regarding Urgent Care.

11.2 INITIAL CLAIM DECISIONS

An initial decision on all Claims will be made as quickly as the situation demands but in no event later than the time frames set forth below:

Action	**Urgent Care Claim**	**Pre-Service Claim**	**Post-Service Claim**
Initial Benefit Decision (from the date the Claim is	72 hours	15 days	30 days

received by PPK)			
Extension (from the date the Claim is received by PPK)	None- If additional information is needed to make a decision, PPK must notify the Member within twenty-four (24) hours after receipt of the Claim. A decision must be made within forty-eight (48) hours of the earlier of: (i) receipt of the information; or (ii) expiration of the time period allowed for the Member to provide the information.*	30 days*	45 days*
Time for Member to provide more information (from the date the information was requested by PPK)	No less than 48 hours	No less than 45 days	No less than 45 days

*The time frames listed are those required by ERISA. A Member may voluntarily agree to provide PPK additional time within which to make a decision.

11.3 PROCESS FOR SUBMITTING AN APPEAL

A Member or the Member's Authorized Representative has the right to obtain, without charge, copies of the documents, relating to the Adverse Decision, including the name of the utilization review organization used to review the Claim and may Appeal an Adverse Decision from an initial Claims decision by:

- submitting the Appeal in writing to 8535 E. 21st Street North, Wichita, Kansas 67206 to the attention of the appeals committee; or
- sending a fax to 316-609-2327; or
- sending an e-mail to phsimail@phsystems.com.

Or, if the Member believes his or her health would be seriously harmed by waiting for a decision under the standard timeframes set forth below, he or she may make an oral request for an Expedited Appeal by calling Member Services at 316-609-2390 or 1-800-660-8114 outside of Wichita. Expedited Appeals are not subject to a second level of appeals.

Appeals should include:

- the Member's name and Member ID number.
- specific information relating to and reason for the Appeal.
- the Member's expectation for resolution.
- copies of medical records or other documentation that the Member wishes to be considered in the Appeal.

All levels of the appeals process will be handled by individuals not involved in a previous determination**.** Appeals involving clinical issues will be reviewed by a practitioner in the same or a similar specialty that typically manages the medical condition, procedure or treatment in question. If time permits, the Member may be referred for a second opinion.

11.4 APPEAL OF INITIAL ADVERSE DECISIONS (FIRST LEVEL APPEAL)

A decision on the first level Appeal will be made as quickly as the situation demands but in no event later than the time frames set forth below:

Action	**Urgent Care Claim**	**Pre-Service Claim**	**Post-Service Claim**
Time to File Appeal (from the date PPK made the initial Adverse Decision)	180 days	180 days	180 days
Initial Appeal Decision (from the date the Appeal is received by PPK)	72 hours	15 days	30 days
Extension (from the date the Appeal is received by PPK)	None*	None*	None*

*The time frames listed are those required by ERISA. A Member may voluntarily agree to provide PPK additional time within which to make a decision.

11.5 APPEAL OF ADVERSE DECISIONS FROM A FIRST LEVEL APPEAL (SECOND LEVEL APPEAL)

If the Member is not satisfied with the outcome of the First Level Appeal on a Pre-Service or Post-Service Claim, he or she has the right to initiate a final appeal in the manner described in the Process for Submitting an Appeal section, above. The Member and/or a designated representative of their choice may attend the Second Level Appeals Committee meeting to present their case or communicate via a conference call. The Member may also record the proceedings of the second level appeals committee meeting at their own expense. A decision on the second level Appeal will be made as quickly as the situation demands but in no event later than the time frames set forth below:

Action	Pre-Service Claim	Post-Service Claim
Time to File Appeal (from the date PPK made the first level Appeal Decisions)	180 days	180 days
Appeal Decision (from the date the Appeal is received by PPK)	15 days	30 days
Extension (from the date the Appeal is received by PPK)	None*	None*

*The time frames listed are those required by ERISA. A Member may voluntarily agree to provide PPK additional time within which to make a decision.

11.6 RIGHT TO WAIVE SECOND LEVEL APPEAL

If the Member has received an Adverse Decision following a first level Appeal due to the fact that the service is not or was not Medically Necessary, or the health care treatment has been determined by PPK to be Experimental or Investigational, and the denial leaves the Member with a financial obligation or prevents the Member from receiving the requested services, the Member may voluntarily waive their right to the second level appeal and proceed directly to pursuing an External Review. The Member must notify PPK in writing of their decision to waive their second level appeal. By waiving their second level appeal, the Member exhausts all available internal appeal procedures.

11.7 PROCEDURE FOR PURSUING AN EXTERNAL REVIEW

- The Member has the right to request an External Review after a final Adverse Decision has been rendered, or when the Member has not received a final Adverse Decision within sixty (60) days of seeking such review, unless the delay was requested by the Member for eligible Claims as defined in the Claims Eligible for External Review. PPK will notify the Member in writing regarding a final Adverse Decision and of the opportunity to request an External Review.
- Within ninety (90) days of receipt of the notice of the final Adverse Decision, the Member, the treating Physician or health care Provider acting on behalf of the Member with written authorization from the Member, or a legally authorized designee of the Member must make a written request for an External Review to the Kansas Insurance Department, 420 S. W. 9th, Topeka, Kansas 66612-1678, or phone toll free at 1-800-432-2484.
- Within ten (10) business days of receipt of such request (immediately, when the request for External Review involves an Emergency Medical Condition), the Kansas Insurance Department will notify the Member and other involved parties as to whether the request for External Review is granted.
- For those requests that qualify for External Review, the External Review Organization will issue a written decision to the Member and the Kansas Insurance Department within thirty (30) days. The External Review Organization will issue its written decision within seven (7) business days when the request for External Review involves an Emergency Medical Condition. If any party is not satisfied with the decision of the External Review organization, they may pursue normal remedies of law.
- The right to External Review shall not be construed to change the terms of coverage under this Certificate. In no event shall more than one (1) External Review be available during the same year for any request arising out of the same set of facts. A Member may not pursue, either concurrently or sequentially, an External Review under both state and federal law. The Member shall have the option of designating which External Review process will be utilized.

11.8 RIGHT TO A JUDICIAL REVIEW

After you have exhausted all available internal appeal procedures, you have the right to sue in federal or state court, even if you do not request External Review. In all events, such suit or proceeding must be commenced no later than five (5) years after the date from the time written proof of loss is required to be given.

SECTION 3 - COORDINATION OF BENEFITS

This coordination of benefits (COB) provision applies when a Member has health care coverage under more than one (1) plan. "Plan" is defined below.

The order of benefit determination rules listed below determine which plan will pay as the primary plan. The primary plan pays first and pays without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100 percent of the total allowable expense.

1. COB DEFINITIONS

1.1 A "plan" is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

- "Plan" includes: group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured); hospital indemnity benefits in excess of $200 per day; medical care components of group long-term care contracts, such as skilled nursing care; and Medicare or other governmental benefits, as permitted by law.
- "Plan" does not include: individual or family insurance; closed panel or other individual coverage (except for group or group type accident only coverages); amounts of hospital indemnity insurance of $200 or less per day; benefits for non-medical components of group long-term care policies; Medicare supplement policies, Medicaid polices and coverage under other governmental plans, unless permitted by law.
- Each contract for coverage is a separate plan. If a plan has two (2) parts and COB rules apply only to one (1) of the two (2), each of the parts is treated as a separate plan.
- The order of benefit determination rules determine whether this plan is a "primary plan" or "secondary plan" when compared to another plan covering the person.
- When this plan is primary, its benefits are determined before those on any other plan and without considering any of the other plan's benefits. When this plan is secondary, its benefits are determined after those of another plan and may be reduced because of the primary plan's benefits.

1.2 "Allowable expense" means a health care service or expense, including deductibles and copayments, that is covered at least in part by any of the plans covering the person. When a plan provides benefits in the form of services, (for example a HMO) the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the plans is not an allowable expense. The following are examples of expenses or services that are not allowable expenses:

- If a Member is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room (unless the patient's stay in a private hospital room is Medically Necessary in terms of generally accepted medical practice, or one (1) of the plans routinely provides coverage for hospital private rooms) is not an allowable expense.
- If a person is covered by two (2) or more plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an allowable expense.
- If a person is covered by two (2) or more plans that provide benefits or services on the basis of negotiated fees, or if one (1) plan calculates its benefits or services on the basis of usual and customary fees and the other plan provides its benefits or services on the basis of negotiated fees, any amount in the excess of the highest of the fees is not an allowable expense.
- The amount a benefit is reduced by the primary plan because a covered person does not comply with the plan provisions. Examples of these provisions are second surgical opinions, pre-certification of admissions, and preferred provider organizations.

1.3 "Claim determination period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under this plan, or before the date this COB provision or a similar provision takes effect.

1.4 "Closed panel plan" is a plan that provides health benefits to covered persons primarily in the form of services through a panel of Providers that have contracted with or are employed by the plan, and that limits or excludes benefits for services provided by other Providers, except in the case of emergency or referral by a panel member.

1.5 "Custodial parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one-half of the calendar year without regard to any temporary visitation.

1.6 "ADEA Employer" is an employer which is subject to the U.S. Age Discrimination in Employment Act (ADEA); and has twenty (20) or more employees each working day in twenty (20) or more calendar weeks during the current or preceding Calendar Year.

1.7 "Medicare Benefits" are benefits for services and supplies which the Member receives or is entitled to receive under Medicare Parts A or B.

2. ORDER OF BENEFIT DETERMINATION RULES

2.1 The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.

2.2 A plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary. There is one (1) exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of basic package of benefits provided by a contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel to provide out-of-network benefits.

2.3 A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.

2.4 The first of the following rules that describes which plan pays its benefits before another plan is the rule to use.

Non-Dependent or Dependent.
The plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two (2) plans is reversed so that the plan covering the person as an employee, member or subscriber or retiree is secondary and the other plan is primary.

Child Covered Under More Than One (1) Plan.
The order of benefits when a child is covered by more than one (1) plan is:
The primary plan is the plan of the parent whose birthday is earlier in the year if:

- the parents are married;
- the parents are not separated (whether or not they ever have been married); or
- a court decree awards joint custody without specifying that one (1) party has the responsibility to provide health care coverage.
- If both parents have the same birthday, the plan that has covered either of the parents longer is primary.

If the specific terms of a court decree state that one (1) of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but the parent's spouse does, the spouse's plan is primary. This rule applies to claim determination periods or plan years commencing after the plan is given notice of the court decree.
If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

- the plan of the custodial parent;
- the plan of the spouse of the custodial parent;
- the plan of the non-custodial parent; and then
- the plan of the spouse of the non-custodial parent.

Active or inactive employee.
The plan that covers a person as an employee, who is neither laid off nor retired, is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined under the rule labeled Non-Dependent or Dependent.

Continuation coverage.
If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

Longer or shorter length of coverage.
The plan that covered the person as an employee, member, subscriber or retiree longer is primary.

If the preceding rules do not determine the primary plan, the allowable expenses shall be shared equally between the plans meeting the definition of plan under this regulation. In addition, this plan will not pay more than it would have paid had it been primary.

3. EFFECT ON THE BENEFITS OF THIS PLAN

3.1 When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a Claim determination period are not more than 100 percent of the total allowable expenses.
As each Claim is submitted, this plan will:

- Determine its obligation to pay or provide benefits under its contract;
- Determine whether a benefit reserve has been recorded for the covered person; and
- Determine whether there are any unpaid allowable expenses during that Claim determination period.
- If there is a benefit reserve, the secondary plan will use the covered person's benefit reserve to pay up to 100% of total allowable expenses incurred during the Claim determination period. At the end of the Claim determination

period, the benefit reserve returns to zero. A new benefit reserve must be created for each new Claim determination period.

3.2 If a covered person is enrolled in two (2) or more closed panel plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one (1) closed panel plan, COB shall not apply between that plan and other closed panel plans.

4. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. PPK may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. PPK need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give PPK any facts it needs to apply those rules and determine benefits payable.

5. FACILITY OF PAYMENT

A payment made under another plan may include an amount that should have been paid under this plan. If it does, PPK may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. PPK will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

6. RIGHT OF RECOVERY

If the amount of the payments made by PPK is more than it should have paid under this COB provision, it may recover the excess from one (1) or more persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

7. COORDINATION WITH MEDICARE

7.1 Scope of Provision

This Provision applies when the Member has Coverage under the Certificate, and is eligible for hospital insurance under Medicare Part A (whether or not the Member has applied or is enrolled for Medicare Benefits). This Provision applies before any other Coordination of Benefits provision of the policy.

7.2 Effect on Benefits

If, in accordance with the following rules, PPK has primary responsibility for the Member's Claims, then PPK pays benefits first. If, in accordance with the following rules, PPK has secondary responsibility of the Member's Claims, first Medicare benefits are determined or paid and then PPK's benefits are paid. However, for services payable under both plans, the combined Medicare Benefits and PPK's benefits will not exceed 100% of eligible medical expenses.

7.3 Rules For Determining Order of Benefits

Subscriber

PPK has primary responsibility for Claims, if:

- the Subscriber is eligible for Medicare Part A or B; and
- the Subscriber is actively employed by an ADEA Employer who pays all or part of the policy's premium.

PPK has secondary responsibility for Claims when a Subscriber is eligible for Medicare Part A or B and is not actively employed by an ADEA Employer who pays all or part of the Company's premium.

Dependent

PPK has primary responsibility for a Dependent's Claim if:

- the Dependent is eligible for Medicare Part A or B*;* and
- the Subscriber is actively employed by an ADEA Employer who pays all or part of the policy's premium.

PPK has secondary responsibility for a Dependent's Claims when he or she is eligible for Medicare Part A or B and the Subscriber is not actively employed by an ADEA Employer who pays all or part of the policy's premium.

Members with End-Stage Renal Disease

PPK has primary responsibility for the Claims of any Member for up to thirty (30) Months from the date:

- a Member begins a regular course of renal dialysis; or
- a Member could be entitled to Medicare after receiving a kidney transplant.

Medicare benefits are secondary only for that portion of the thirty (30) month period remaining after the Member becomes eligible for Medicare. Thereafter, Medicare benefits are primary, and PPK's benefits are secondary.

Members under Non-ADEA Employer Plans

PPK has secondary responsibility for Claims of any Member if the employer under the policy is not an ADEA Employer.

SECTION 4 - GENERAL PROVISIONS

1. CERTIFICATES, IDENTIFICATION CARDS, AND CHANGES IN THE GROUP CONTRACT AND CERTIFICATES

1.1 PPK will issue the identification cards and Certificates of Coverage for Subscribers of the Group. Identification cards issued by PPK pursuant to this Coverage are for identification only and possession of a PPK identification card confers no right to services or benefits under the Group Contract. To be entitled to such services or benefits, the holder of the card must, in fact, be a Member on whose behalf all applicable charges under the Group Contract have actually been paid.

1.2 The provisions of the Certificate of Coverage may be changed by PPK by giving thirty (30) days prior written notice to the Group, and evidenced by issuance of a new Certificate of Coverage or a rider, amendment, endorsement (or other proper written means) to this Certificate of Coverage.

2. REIMBURSEMENT FOR SERVICES

2.1 The Member may be required to share the cost of Covered Services as described in the Summary of Benefits.

2.2 For Covered Services rendered by Contracting Providers, the Contracting Provider will submit a Claim(s) to PPK on the Member's behalf requesting reimbursement. PPK will make payment directly to the Contracting Provider for Covered Services.

2.3 There will be occasional Covered Services (such as out-of-area Emergency Services) where the Member may be required by the Provider of service to pay for the services. If the Member then furnishes evidence satisfactory to PPK that he/she has made payment to such Provider for a service covered by this Certificate of Coverage, PPK will reimburse the Member directly for the benefits due.

2.4 Prompt Filing of Claims - Notice of the Member's Claim must be given to PPK within ninety (90) days after he/she receives services. If the Member's Provider does not submit a Claim, the Member must do so himself/herself. If the Member needs help submitting a Claim, he/she should call or write PPK. If it is not reasonably possible for the Member to submit a Claim within ninety (90) days after he/she receives services, he/she or someone authorized by him/her must submit the Claim as soon as reasonably possible. No Claim will be paid if not received by PPK within one (1) year and ninety (90) days after services are received.

3. MISCELLANEOUS

3.1 Member Authorizes PPK to Receive Needed Information

PPK is entitled to receive from any Provider of services to Members, information reasonably necessary in connection with the administration of this Certificate, but subject to all applicable confidentiality requirements. By accepting Coverage under this Certificate, the Member authorizes every Provider rendering services hereunder to disclose all facts pertaining to such care and treatment and physical condition of the Member to PPK upon request, and render reports pertaining to the same, and permit copying of records by PPK.

3.2 Confidentiality

Information from medical records of Members and information received from Health Professionals, Hospitals, or any other Providers of medical care services incident to the doctor-patient or hospital-patient relationship shall be kept confidential; and, except as required or permitted by law may not be disclosed without authorization of the Member.

3.3 Applications and Statements

Members or applicants for membership shall complete and submit to the Group such applications, or other forms or statements, as the Group may reasonably request. The only statements a Member makes that may be used in any legal action concerning the Certificate of Coverage issued thereunder are statements that are in writing. Any such written statement will be considered a representation and not a warranty.

3.4 Authority to Change the Contract

No agent or representative of PPK other than its executive officers is authorized to change the Group Contract or waive any of its provisions.

3.5 Legal Action

No action at law or in equity shall be brought to recover on the Group Contract unless brought within five (5) years of the date the loss is incurred.

3.6 Cooperation with Claims Investigation

A Member shall cooperate with PPK in the benefit determination process and regarding the investigation of Claims relating to Covered Services, Coordination of Benefits, Medical Necessity determinations, utilization review and fraud and abuse functions. This duty to cooperate includes, but is not limited to, providing upon request by PPK a written statement and/or testimony under oath regarding any Claim where the Member's name, identification or identity is utilized. Failure to cooperate may result in a delay in payment of the Covered Service(s) and/or denial of the Claim(s).

3.7 Notices

Notices to PPK should be addressed to Preferred Plus of Kansas, PO Box 49288, Wichita, Kansas 67201. Notices from PPK to a Member will be addressed to the Subscriber at the Subscriber's latest address on PPK's records, as permitted by law.

3.8 Disaster Limitation

Benefits are limited to the extent that a natural disaster, war, riot, civil insurrection, epidemic or any other emergency or similar event not within the control of PPK results in the facilities, personnel, or financial resources of PPK being unavailable to provide or arrange for the provision of such services, PPK and Contracting Providers will render Hospital and Medical Services provided under this Certificate in so far as practical and according to their best judgment, but PPK and Contracting Providers shall incur no liability or obligation for delay or failure to provide or arrange for services if such failure or delay is caused by such an event.

4. INAPPLICABLE OR INCONSISTENT PROVISIONS

If any provision of this Certificate of Coverage is in whole or in part inapplicable to, or inconsistent with the Coverage provided by this Certificate of Coverage, PPK with the approval of the commissioner of insurance, will modify any inconsistent provision in such manner as to make it consistent with the Coverage provided by the Certificate of Coverage.

SECTION 5 - PLAN PROVISIONS

Subject to all terms, conditions, and definitions in this Certificate of Coverage, Members are entitled to receive the Covered Services set forth in this section if they are provided, prescribed or referred by your PCP and, if applicable, prior authorized by PPK. You and your PCP or treating Physician, not PPK or the Group, determine the course of medical treatment. PPK only makes decisions regarding whether a Health Care Service is a Covered Service. The following services do not require a PCP Referral Authorization or Prior Authorization by PPK: Emergency Services, annual well-woman exam, annual well man exam, routine vision exam, annual diabetic retinal eye exam, and prospective parent PCP visit.

Behavioral health and substance abuse services do not require a PCP Referral Authorization; however, they must be prior authorized by PPK as stated in the Prior Authorization Process section.

To obtain PPK's Contracting Provider Directory, contact the Member Services department at 316-609-2555 or 1-866-618-1691 (outside Wichita) or visit our web site at www.phsystems.com.

1. COPAYMENTS AND OUT-OF-POCKET MAXIMUM

1.1 COPAYMENTS

The Member will be responsible for paying the Copayments listed on the attached Schedule of Benefits.

1.2 OUT-OF- POCKET COINSURANCE MAXIMUM

After the out-of-pocket Coinsurance maximum has been met, benefits will increase to 100% of the Allowed Amounts for the remainder of the Benefit Period. The following do not count toward meeting the out-of-pocket Coinsurance maximum:

- Copayments
- Outpatient behavioral health and substance abuse (BH/SA) services

2. REFERRAL AUTHORIZATION PROCESS

As a Member of PPK, you are responsible for obtaining a Referral Authorization from your PCP for all Health Care Services (except Emergency Services, annual well-woman exam, annual well man exam, routine vision exam, annual diabetic retinal eye exam, and prospective parent PCP visit) rendered outside his/her office. The PCP must submit a written Referral Authorization Form to PPK for approval prior to such Health Care Services being rendered. A PCP Referral Authorization does not, in and of itself, guarantee the Health Care Services will be covered by PPK. You should ask for a copy of the Referral Authorization Form. The form will specify:

- Who you will be seeing or where to obtain an item;
- What treatment or item is authorized;
- The time frame authorized;
- The number of visits authorized (if specified); and
- If testing is to be done by the Specialist Physician or by your PCP.

3. PRIOR AUTHORIZATION PROCESS

Prior Authorization is required for certain Health Care Services as determined by PPK. Coverage is subject to eligibility and benefits remaining at the time services are rendered. PPK has the right to request and obtain whatever medical information it considers necessary to determine whether the service is Medically Necessary.

3.1. Participating Providers (either your PCP, the Specialist Physician, or other Health Professional) are required to contact PPK for Prior Authorization, except for those services stated below in 2.2. If the service is deemed not Medically Necessary, you and the Provider will be notified.

3.2. The Member is responsible for contacting PPK for Prior Authorization of behavioral health and substance abuse. Prior Authorization may be obtained by calling 316-609-2541 or 1-866-338-4281 (outside Wichita), Monday-Friday, 8a.m.-5p.m. Staff is available after hours and on weekends and holidays to assist Members with urgent situations.

The Prior Authorization List (Exhibit A) is subject to change. An up-to-date Prior Authorization List can be found at www.phsystems.com or by calling Member Services at 316-609-2390 or 1-800-660-8114 (outside Wichita).

4. SERVICES FROM NON-CONTRACTING PROVIDERS

The Member's PCP will refer and PPK will prior authorize Covered Services only to Contracting Providers. If a Member receives non-emergency Covered Services from a Non-Contracting Provider, the Member will be responsible for the Non-Contracting Provider's actual billed charges and PPK will provide no benefits under this Certificate. If PPK determines that no Contracting Provider could provide the service, PPK will prior authorize such service subject to any applicable Copayment or Coinsurance amounts.

5. CASE MANAGEMENT/COST EFFECTIVE CARE

5.1. Case management is a program conducted by PPK that:

- Identifies cases involving a Member in a clinical situation that presents either the potential for catastrophic Claims or a utilization pattern that exceeds the norm.
- Assesses the appropriateness of the level of patient care and the setting in which it is received.
- Develops, introduces and implements viable alternate treatment plans for such cases that maintain or enhance the quality of patient care.
- Provides cost controls through implementation of the alternate treatment plan developed through discussion and agreement with the Member or legal representative, the attending Physician and PPK.

This treatment plan may include both Covered Services and Non-Covered Services. Benefits for those services cannot exceed the lifetime benefit maximum under the Member's Coverage. Payment of benefits for such services or supplies shall be subject to the terms and provisions of this Certificate of Coverage. No Member is required to accept an alternate treatment plan recommended by the case manager. However, if you decline the alternate treatment plan, your benefits may be reduced or denied.

5.2. To accomplish cost-effective care, PPK has the right to authorize Coverage of services in the least expensive setting that meets the needs of the patient. Such cost-effective services may include, but are not limited to, skilled nursing care, outpatient diabetic treatment, hospice services, and home health nursing care.

6. TRANSFER OF CARE

If a Member is admitted for emergency care to a Facility that does not contract with PPK, or in the case of an unexpected length of stay after a prior authorized admission to a Facility that does not contract with PPK, the Primary Care Physician and PPK may request that the Member be transferred to a Contracting Provider for continuation of care when it is not medically contraindicated. If the Member refuses to be transferred to a Contracting Provider, PPK will not cover any services beyond the proposed date of transfer.

7. BENEFITS

Refer to the Prior Authorization section of this certificate and Exhibit A for Prior Authorization requirements.

AMBULANCE SERVICES

Members will be entitled to ambulance service if Medically Necessary or if use of such ambulance service is required to transport the Member in the event of an Emergency Medical Condition.

BEHAVIORAL HEALTH AND SUBSTANCE ABUSE

Covered benefits under this section are those specified in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, (DSM-IV, 1994) of the American Psychiatric Association.

Non covered services include conditions not attributable to a mental disorder that are a focus of attention or treatment including, but not limited to, psychological factors affecting a medical condition, relational problems, and religious or spiritual problems. Services for the treatment of Biologically Based Mental Illness are not covered under this benefit.

1. Inpatient treatment

Inpatient treatment of behavioral health and substance abuse in facilities licensed under K.S.A. 65-429, 65-4014, 65-4605 and 75-3307b or in other treatment facilities will be provided up to a total of sixty (60) days per Member, per Benefit

Period. An observation stay of twenty-four (24) hours or longer will be treated as an inpatient admission. Each partial day session will be counted as one-half of an inpatient day toward the sixty (60) day per Member, per Benefit Period maximum.

2. Outpatient treatment

Outpatient treatment for behavioral health and substance abuse, including biofeedback, are provided when services are obtained from a Hospital, Facility, licensed Physician, a licensed psychologist, a licensed specialist clinical social worker or other Providers licensed under the laws of the State of Kansas, or under similar laws in states other than Kansas to diagnose and treat mental disorders and who are acting within the scope of such license.

Coverage will be provided for structured group therapy programs, when required for the diagnosis and treatment of abuse or addiction to either alcohol or drugs or mental disorders when authorized by PPK. Each group therapy session will be counted as one-half a visit and only 50% of the Copayment charged for individual therapy sessions will be charged for group therapy sessions.

The first three (3) outpatient visits will be covered at 100% of Allowed Amounts, the next twenty-two 22 visits will require a $25 office visit Copayment, and all other visits will be covered at 50% of Allowed Amounts per Benefit Period**.** A visit means a PPK authorized Member encounter for evaluation, examination, testing or treatment. All services rendered on the same day by the same Provider will count as one (1) visit.

Coverage for Biologically Based Mental Illness as defined in this agreement will not be subject to the provisions of this section.

DIABETIC SERVICES

Outpatient self-management training, and education for diabetes will be covered if treated through an approved program, and such treatment is rendered by a person certified by the National Certification Board of Diabetes Educators.

Glucometers, insulin pumps and insulin pump supplies used for the self-management of diabetes are covered without dollar limitation when deemed Medically Necessary, ordered by your PCP and purchased from a Contracting Provider. Other supplies used for the self-management of diabetes including, insulin, syringes, alcohol swabs, glucose test strips (blood and urine), ketone testing strips and tablets, lancets and lancet devices are covered under the State's prescription benefit. Therefore, they are not covered by PPK.

Members may self-refer to a Contracting Provider for an annual diabetic retinal eye examination.

DURABLE MEDICAL EQUIPMENT/DISPOSABLE MEDICAL SUPPLIES

Durable Medical Equipment, associated supplies and certain disposable medical supplies will be covered up to the maximum dollar amount as indicated in the Schedule of Benefits when deemed Medically Necessary and ordered by the Primary Care Physician. Coverage for disposable medical supplies is limited to the following:

1. Ostomy supplies (appliance pouches, skin care agents, support belts);
2. Open wound supplies (gauze pads, wound packing strips, ABD pads);
3. Venous access catheter supplies (alcohol pads, benzoin, OP site);
4. Urinary supplies limited to catheters, bags and related supplies;
5. Tracheostomy supplies;
6. Inhaler supplies (aero chamber masks, spacers, and peak flow meters);
7. Compression gloves and sleeves;
8. Compression stockings; and
9. Mastectomy supplies.

Following a mastectomy, coverage will be provided for either two (2) bras or two (2) camisoles or a combination of one (1) each, per Member, per Benefit Period.

Durable Medical Equipment relating to oxygen, a wound vacuum system, tube feedings, IV infusion pumps, and associated supplies is not subject to the maximum dollar amount as indicated in the Schedule of Benefits.

Coverage will be provided for enteral nutrition (tube feedings) if:

1. The medical records indicate the Member's medical condition has existed longer than three (3) months; and
2. The Member's medical condition prevents food from reaching the intestines; and
3. The condition requires tube feedings to provide sufficient nutrients to maintain weight and strength. Adequate nutrients must not be possible by dietary adjustment and/or oral supplements.

Limitation:

Enteral pumps and supplies will be covered only when the above criteria are met.

Exclusions (even if the above criteria are met):

1. Enteral products that can be administered orally.
2. Products that can be purchased over-the-counter, which do not require a prescription by federal or state law, including, but not limited to, formula, Ensure®, Pediasure®**,** and Nutren®.

EMERGENCY SERVICES/URGENT CARE SERVICES

1. Emergency Services

PPK will provide coverage for Emergency Services if the symptoms presented by the Member and recorded by the attending Physician indicate that an Emergency Medical Condition exists, or for Emergency Services necessary to provide a Member with a medical examination and stabilizing treatment, regardless whether Prior Authorization was obtained to provide those services. An Emergency Medical Condition is a medical condition manifesting itself by acute symptoms of such severity that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the Member's health in serious jeopardy. Examples of Emergency Medical Conditions include but are not limited to, heart attacks, cerebrovascular accidents, poisoning, convulsions and severe bleeding. Examples of care that do not qualify as Emergency Medical Conditions are rashes, coughs, colds, sore throats, ear infections, and nausea.

Services provided by an emergency Facility for non-Emergency Medical Conditions are not covered.

Emergency Services within the Service Area should be obtained from the Member's Primary Care Physician or other Contracting Providers. Contracting Providers are available on call twenty-four (24) hours a day, seven (7) days a week, to assist Members needing care for Emergency Medical Conditions. If you receive Emergency Services from a non-contracting Hospital within the Service Area, such services will only be covered in situations where you had no control over when or where such services were rendered.

Whether in or outside of the Service Area, the Member and/or health care Facility should promptly contact the Primary Care Physician for Prior Authorization for continuing treatment, Hospital admission, specialty consultations, transfer arrangements or other Medically Necessary and appropriate care for the Member. After Emergency Services have been rendered, follow-up treatment will not be covered, unless authorized in advance by the Member's Primary Care Physician or their authorized representative.

2. Urgent care services

A condition that requires urgent care is an unexpected illness or injury that is not life-threatening but requires prompt medical attention. Examples of urgent care conditions include flu, sore throat, ear infection, nausea and vomiting. urgent care services within the Service Area should be obtained from the Member's Primary Care Physician or other contracting urgent care facilities. PCPs or their covering physicians are available on call twenty-four (24) hours a day, seven (7) days a week, to assist Members needing care for urgent care conditions.

urgent care is only covered for services rendered at an urgent care Facility, or if out of the Service Area, in an office setting. There is no coverage for urgent care at an emergency Facility, unless you are directed to seek care by your PCP.

Copayments: Members will be responsible for the emergency room Copayment for care received in a Hospital emergency department. Members will be responsible for the applicable Specialist Physician office visit Copayment for urgent care Services received in an urgent care Facility. Copayment(s) will be waived if the Member is admitted to the Hospital within twenty-four (24) hours after seeking care for an Emergency Medical Condition. An observation stay of twenty-four (24) hours or longer will be treated as an inpatient admission, therefore any applicable inpatient Copayment(s) will apply.

EXPERIMENTAL OR INVESTIGATIONAL TREATMENT

Coverage for Experimental or Investigational treatment is limited to an approved clinical trial. An approved clinical trial is a scientific study of a new therapy or intervention for the treatment, palliation, or prevention of a disease that meets the following specific criteria:

1. The treatment or intervention is provided pursuant to an approved clinical trial that has been authorized or approved by one (1) of the following:
   - The National Institutes of Health as a Phase II or III trial;
   - The United States Food and Drug Administration in the form of an Investigational new drug (IND) exemption as a Phase II or III designation; or
   - The National Cancer Institute as a Phase II or III trial.
2. The proposed clinical trial has been reviewed and approved by a national or local Institutional Review Board ("IRB") which is routinely audited by a federal agency such as the Office for Protection from Reasonable Risk (OPRR). The available clinical data indicates that the treatment or intervention provided pursuant to the approved clinical trial will be at least as effective as standard therapy, if such therapy exists, and is anticipated to constitute an improvement in effectiveness for treatment, prevention, or palliation of the disease.
3. The Facility and personnel providing the treatment are capable of doing so by virtue of their experience and training.
4. The trial consists of a scientific plan of treatment that includes specified goals, a rationale and background for the plan, criteria for patient selection, specific directions for administering therapy and monitoring patients, a definition of quantitative measures for determining treatment response, and methods for documenting and treating adverse outcomes.

Coverage will be provided for:
Expenses associated with professional services, diagnostic laboratory and radiology tests, inpatient care, and administration of treatment and evaluation of the patient during the course of the treatment or a condition associated with a complication of the underlying disease or treatment, which are consistent with usual and customary patterns and standards of care incurred whenever a patient receives medical care associated with an approved clinical trial, and which would be covered if such items and services were provided other than in connection with an approved clinical trial.

Exclusions:

1. The costs of the Investigational drugs or devices themselves, or the costs of any non-medical services that might be required for the patient to receive the treatment or intervention.
2. Transportation and/or lodging costs incurred while receiving such treatment.
3. Costs, fees or other reimbursements for which funding was or could have been provided within the funding for the clinical trial authorization.

GENETIC TESTING

Genetic testing is covered to establish a molecular diagnosis of an inheritable disease when all of the following are met:

1. The Member displays clinical features, or is at direct risk of inheriting the mutation in question (pre-symptomatic); and
2. The result of the test will directly impact the treatment being delivered to the Member; and
3. If after a comprehensive medical history, physical examination, pedigree analysis, genetic counseling and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain.

Exclusions:

1. Genetic testing when performed primarily for screening purposes.
2. Genetic testing when performed primarily for the medical management of other family members who are not covered under PPK.
3. Genetic testing when performed primarily for purposes of embryonic pre-selection.

HOME HEALTH SERVICES

Home health services will be provided for up to the maximum benefit as indicated in the Schedule of Benefits if the Member requires skilled care and is homebound due to a disabling condition, is unable to receive medical care on an ambulatory outpatient basis, and does not require confinement in a Hospital or other participating Facility. Home health services must be provided by an accredited participating Home Health Agency. Home health services include:

1. Periodic and intermittent diagnostic and therapeutic services by professional nurses and other participating Health Professionals if the services are ordered by a Physician and approved by the Primary Care Physician and if the services are of the type, which can only be performed by a licensed health care professional;
2. Consumable medical supplies and durable medical equipment administered or used by such persons in the course of services rendered during such visits;

Limitations:

1. Physical, occupational, and speech therapy are subject to the benefit limitations as described in the Rehabilitation Services section of this Certificate and the Schedule of Benefits.
2. Intravenous and injectable medications are subject to the benefits as described in the Intravenous and Injectable Medications section of this Certificate and the Schedule of Benefits.

Exclusions:

1. Custodial or private duty nursing on a shift basis, or otherwise, whether or not required by a Physician;
2. Services of a person who is a family member of the Member or who normally resides in the Member's home;
3. Assistance in the activities of daily living including, but not limited to: eating, bathing, dressing or other custodial or self-care activities, such as self-medicating, homemaker services, or private duty nursing, whether or not required by a Physician; and
4. Convalescent care, custodial care, respite care for care-givers or rest cures.

HOSPICE SERVICES

Hospice services are limited to the maximum dollar amount as indicated in the Schedule of Benefits when a Member has a life expectancy of less than six (6) months. Covered services include:

1. Outpatient home health services, including intermittent and periodic visits by professional nurses and social workers;
2. Services of a psychologist, social worker or family counselor for individual and family counseling;
3. Bereavement counseling; and
4. Drugs related to the terminal disease, which have been approved by the FDA and have a National Drug Code, and not covered under a drug plan.

Exclusions*:*

1. Services of a person who is a family member of the Member or who normally resides in the Member's home;

2. Services or supplies not listed in the hospice's care program;
3. Services for curative or life-prolonging procedures;
4. Services for which any other benefits are payable under this Certificate;
5. Nutritional supplements, non-prescription drugs or substances, vitamins or minerals;
6. Assistance in the activities of daily living including, but not limited to eating, bathing, dressing or other custodial or self-care activities, homemaker services, private duty nursing whether or not required by Physician; and
7. Convalescent care, custodial care, respite care for care-givers or rest cures.

INPATIENT HOSPITAL AND FACILITY SERVICES

Inpatient hospital and Facility services will be provided for evaluation or treatment of conditions that cannot be adequately treated on an ambulatory or outpatient basis. All inpatient admissions will be assessed a copayment, except newborn children discharged on the same date as the mother. All inpatient admissions are subject to Coinsurance.

Exclusions:

1. Private duty nursing whether or not required by Physician;
2. Convalescent care, custodial care, respite care for care-givers or rest cures;
3. Additional charges for private room and board;
4. Convenience items; and
5. Drugs for take home use.

INTRAVENOUS AND INJECTABLE MEDICATIONS

FDA approved intravenous (IV) and injectable medications, which have a National Drug Code, will be covered as deemed medically necessary and ordered by a Physician.

Exclusion:

Injectable medications covered under the State of Kansas prescription drug benefit.

MATERNITY CARE

Maternity care includes medical, surgical and Hospital care during pregnancy, upon delivery and during the postpartum period for normal delivery, spontaneous abortion (miscarriage) and complications of pregnancy. The Member and her newborn child are allowed at least a forty-eight (48) hour Hospital stay for a routine birth and a ninety-six (96) hour Hospital stay for a cesarean section after delivery. The coverage for the Member's newborn child under this section only extends to the time frame the Member is an inpatient in a Hospital following the delivery of such newborn child. If the period is shortened, it must be agreed upon between the Member and her Primary Care Physician.

Maternity care also includes obstetrical and delivery expenses for the birth mother of a child adopted by the Subscriber within ninety (90) days of the birth of such child. If services are rendered by a Non-Contracting Provider, you will be responsible for the difference between the Provider's billed charges and PPK's Allowed Amounts.

PPK will pay for one (1) visit to the Primary Care Physician a prospective parent intends to select for their newborn child. The visit would occur prior to the birth of the child. If the prospective parent chooses not to select the Physician visited, PPK will not pay for a visit to another Physician.

A Member who attends a child birth preparation class at a participating Hospital or from a participating OB/GYN will be reimbursed by PPK for 50% of the cost not to exceed a maximum benefit of $30.00. A reimbursement form and proof of payment and class completion must be submitted to PPK's Member Services Department.

Exclusions:

1. Scheduled delivery in the home setting.
2. Amniocentesis, ultrasound or any other procedures requested solely for sex determination of a fetus, unless Medically Necessary to determine the existence of sex-linked genetic disorder.

ORAL SURGERY AND OTHER RELATED SERVICES

PPK will pay for the following limited dental services:

Administration of general anesthetic and Facility charges determined by PPK to be Medically Necessary for dental care, and provided to the following persons:

1. Dependent children five (5) years of age or under; or
2. A Member who is severely disabled; or
3. A Member who has a medical or behavioral condition which requires hospitalization or general anesthesia when dental care is provided.

Benefits for oral surgical procedures of the jaw or gums will be covered for:

1. Removal of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;

2. Removal of symptomatic exostoses (bony growths) of the jaw and hard or soft palate;
3. Treatment of fractures and dislocations of the jaw and facial bones;
4. Laceration of mouth, tongue or gums;
5. Intraoral x-rays in connection with covered oral surgery;
6. General anesthetic for covered oral surgery; and
7. Biopsies and associated lab work in connection with covered oral surgery.

Note: All Claims for treatment of accidental trauma to sound natural teeth should be processed by the State's dental plan. Services covered by the State's dental plan are not eligible for additional payment by the medical plan.

ORTHOTIC DEVICES

PPK will cover one (1) orthotic device per Member, per extremity/trunk, per lifetime, unless repair and/or replacement as a result of normal usage or change in condition, including growth, is Medically Necessary. Examples of covered orthotic devices include, but are not limited to, orthopedic braces and shoes that are part of a brace.

Limitation:

Adjustments, repairs and replacements are covered as long as the device continues to be Medically Necessary.

Exclusion:

Customized shoe inserts, special shoes, and over-the counter shoe inserts.

OUTPATIENT SERVICES

Outpatient services consist of all services requested or directed by PPK or the Member's PCP to be provided on an outpatient basis, including:

1. Major diagnostic tests and/or treatment services;
2. Bone density testing (for preventive care bone density screening, refer to the Preventive Services section);
3. Lab and x-ray services;
4. Administered drugs, medications, biologicals, and fluids that have been approved by the FDA, have a National Drug Code, and are administered under the supervision of a Physician;
5. Administration and processing of blood and blood products; and
6. Services that can be appropriately provided on an outpatient basis such as certain surgical procedures which can include anesthesia, recovery room services, ambulatory surgical centers and Hospital outpatient surgical centers.

PHYSICIAN SERVICES

Physician services include diagnostic and treatment services by contracting Physicians and other contracting Health Professionals. This includes office visits, periodic health assessments (such as school and camp physicals), Hospital care consultation, and surgical or non-surgical office procedures.

PREVENTIVE SERVICES

Coverage will be provided for the following services once annually unless otherwise indicated:

1. Well baby and well child care exams as age appropriate when provided by the Member's PCP;
2. Routine childhood immunizations in accordance with accepted medical practice. Routine and necessary immunizations will be provided for all newly born enrolled Dependent children consisting of:
   - At least five (5) doses of vaccine against diphtheria, pertussis, and tetanus,
   - At least four (4) doses of vaccine against polio and Haemophilus B (Hib),
   - At least three (3) doses of vaccine against Hepatitis B,
   - At least two (2) doses of vaccine against measles, mumps, and rubella,
   - At least one (1) dose of vaccine against varicella (chicken pox), and
   - Other vaccines and dosages as may be prescribed by the Secretary of Health and Environment;

   Benefits will apply to immunizations administered to Dependent children up to seventy-two (72) months of age and will not be subject to any Copayment or Coinsurance requirements.
3. Routine immunizations for Members over seventy-two (72) months of age;
4. Routine physical exam when provided by the Member's PCP;
5. General health lab panel and/or lipid panel screening;
6. Comprehensive metabolic panel screening;
7. Cholesterol and/or triglyceride screening;
8. Complete blood count screening;
9. Creatinine screening;
10. Thyroid stimulating hormone (TSH) screening;
11. Screening urinalysis;

12. Colonoscopy for colorectal cancer screening as age appropriate;
13. Digital rectal exam;
14. Fecal occult blood screening;
15. Routine well woman exam when provided by the Member's PCP or a contracting OB/GYN (no referral required);
16. Routine mammogram;
17. Routine Pap test;
18. Screening vaginal culture/smear;
19. Bone density screening;
20. Routine well man exam when provided by the Member's PCP or a contracting urologist (no referral required);
21. Screening PSA exam;
22. Routine hearing exam;
23. Routine eye exam and refraction when provided by a Contracting Provider (no referral required); and
24. Dietitian consultations.

Limitation:

Any follow-up services and/or additional visits do require a referral authorization from the Member's PCP.

Exclusions:

1. Physical examinations strictly for the purpose of participating in athletic, school, or camp activities for Members age twenty-six (26) and older; and
2. Charges for completion of insurance claim forms, specialty reports, and physical examination forms.

PROSTHETIC DEVICES

PPK will cover one (1) prosthetic device per Member, per extremity, per lifetime unless repair and/or replacement as a result of normal usage or change in condition, including growth, is Medically Necessary. Examples of covered prosthetic devices include, but are not limited to, artificial legs, arms, eyes, and breast prostheses following a mastectomy. Stump stockings and harnesses are covered when they are essential to the effective use of an artificial limb.

Limitations:

1. External mastectomy forms are limited to two (2) per Member, per Benefit Period.
2. Benefits are limited to a basic device, which allows necessary function. Charges for deluxe or electrically operated prosthetic devices are not covered.
3. Adjustments, repairs and replacements are covered as long as the device continues to be Medically Necessary.

Exclusions:

1. Benefits are not provided for eyeglasses and contact lenses (except as specified in the Vision Services section of this Certificate), hearing aids, hair prosthesis, dental plates, bridges, braces, or any dental prostheses.
2. External and internal prosthetic medical appliances, which are Experimental or Investigational.

RECONSTRUCTIVE TREATMENT/SURGERY

PPK will pay for reconstructive treatment or surgery only under the following circumstances:

1. Correction/repair of congenital anomalies or those resulting from a disease or injury if determined to be Medically Necessary by PPK.
2. Incidental to a mastectomy, Coverage will be provided in the manner determined in consultation with the treating Physician and the Member. The Member will be provided coverage for:
    - Reconstruction of the breast on which the mastectomy was performed;
    - Surgery and reconstruction of the other breast to produce a symmetrical appearance;
    - Prostheses as outlined in the Prosthetic Devices section of this Certificate and physical complications from all stages of the mastectomy, including lymphedemas; and
    - Bras and/or camisoles following the mastectomy will also be covered if purchased from a Contracting Provider as outlined in the Durable Medical Equipment / Disposable Medical Supplies section of the Certificate.
3. Removal of skin lesions that interfere with normal body functions or which are suspected to be malignant.

Exclusions:

Cosmetic therapies or surgical procedures primarily to restore or alter the appearance including, but not limited to:

1. Surgical excision or reformation of any sagging skin on any part of the body such as eyelids, face, neck, abdomen, arms, legs or buttocks;
2. Services performed in connection with the enlargement, reduction, implantation or change in appearance of a portion of the body such as breasts, face, lips, jaw, chin, nose, ears or genitals;
3. Hair transplantation;
4. Chemical face peels or abrasions of the skin;
5. Electrolysis or depilation; and
6. Botox injections.

REHABILITATION SERVICES

Unless specified otherwise in this Certificate the following rehabilitation services are those designed to help restore the physical functions following injuries, surgery or acute medical conditions:

1. Physical therapy;
2. Occupational therapy;
3. Speech therapy;
4. Respiratory therapy;
5. Neuropsychological testing;
6. Cardiac rehabilitation;
7. Spinal manipulation services; and
8. Pulmonary rehabilitation.

Facility Based Inpatient and Outpatient Services

Inpatient and outpatient rehabilitation services are covered as Medically Necessary for acute care following injuries, surgery, or for acute medical conditions only if significant improvement is shown within thirty (30) days of the first treatment, as determined by PPK. PPK may conduct periodic evaluations as required to assure continued medical necessity.

Office Based Services

Services rendered in the office setting are subject to a maximum benefit of thirty (30) visits per Benefit Period. Services are covered as Medically Necessary.

Exclusions for all rehabilitation services:

1. Long-term rehabilitation.
2. Convalescent care or custodial/maintenance care.
3. Vocational rehabilitation including, but not limited to, employment counseling and training.
4. Cognitive therapy including, but not limited to, behavioral training, educational testing and therapy, dyslexia testing and treatment, learning disabilities and/or mental retardation testing and treatment.
5. Developmental therapy.
6. Athletic evaluation and training.

REPRODUCTIVE HEALTH SERVICES

Covered services include:

1. Office visits, medical evaluation, and counseling;
2. Testing required to establish the etiology of infertility, which is limited to sperm counts, hysterosalpingogram, diagnostic laparoscopy, and endometrial biopsy;
3. Surgical correction of physiological abnormalities causing infertility;
4. Three (3) attempts for artificial insemination, per Member, per Benefit Period; however, laboratory, x-ray, and other testing associated with artificial insemination are not covered.
5. Implantable/injectable contraceptives; and
6. Sterilization procedures (vasectomy or tubal ligation).

Limitations:

1. Abortion and abortion related services will be covered in the following:
   - where the life of the mother would be endangered if the fetus were carried to term;
   - termination of a tubal pregnancy;
   - prior to the 8th week of pregnancy if the pregnancy is the result of an act of rape or incest;
2. Medical complications that have risen from an abortion will be covered.

Exclusions:

1. Fee associated with donors;
2. Collection or storage of sperm;
3. Those services related to conception through artificial means including, but not limited to, in-vitro fertilization (IVF), gamete intrafallopian transfer (GIFT) and similar procedures;
4. Injectable drugs for stimulation of ovaries or treatment of infertility and associated office visits, injections, laboratory, and other testing, including those provided in any Physician's office setting;
5. Embryo transplants;
6. Reversal of voluntarily induced sterilization;
7. Expenses of surrogate motherhood;
8. Any experimental procedure; and
9. Office visits, laboratory, x-ray and other testing associated with any non-covered service.

For maternity care coverage, refer to the Maternity Care section of this Certificate and Schedule of Benefits.

TRANSPLANTS

Benefits are provided for the following transplants: cornea; heart; heart-lung; kidney; pancreas, whole or segmental when simultaneous with kidney transplant; liver; lung (single or double), intestinal, and bone marrow (autologous or allogenic).

1. Coverage for organ procurement includes search and acquisition, organ transportation and compatibility testing. Organ procurement costs also include donor transportation, hospitalization and surgery where a live donor is involved.
2. An office visit for a dental examination and x-rays required as part of the transplant will be covered. Any additional dental treatment/services will not be covered.
3. Transportation and lodging costs for the Member and one (1) family member will be provided if the transplant is performed outside the PPK Service Area or when the Member resides more than fifty (50) miles from the transplant site. Travel expenses shall be defined as commercial transportation of the Member receiving the transplant and a companion, to and from the site of the transplant. Reasonable and necessary lodging and meal costs, limited to $250 per day, incurred by the companion and Member during the Transplant Benefit Period are included. Associated travel expenses are limited to a maximum benefit of $8,000 per Transplant Benefit Period. The Transplant Benefit Period shall mean the period twenty-four (24) hours prior to the Member's hospitalization through the forty-eight (48) hour period after Member's discharge.

Limitations:

1. The benefits of this section are available only when the condition for which the treatment is being proposed would not render the treatment non-covered through application of the Experimental or Investigational definition.
2. Transplant benefits will be available only where a Facility designated by PPK is utilized and the Member is the recipient of an organ transplant.

Exclusion:

No benefits will be available when the Member is a donor.

VISION SERVICES

Covered vision services include:

1. One (1) routine eye exam and refraction, as described in the Preventive Services section of this Certificate.
2. Up to a maximum of $150 for eyeglasses or contact lenses if purchased within six (6) months following cataract and cornea transplant surgery.
3. Annual diabetic retinal eye examination. Refer to the Diabetic Services section.
4. Vision exams, testing, and treatment for medical conditions. Examples of medical conditions include, but are not limited to: cataract, glaucoma, corneal abrasion, foreign body in the eye, and retinal detachment.

Exclusions:

1. Vision hardware except as described in item b. under the Covered Vision Services section above.
2. Contact lens fitting.
3. Surgical treatment for the correction of a refractive error, including but not limited to: radial keratotomy, LASIK, or refractive lensectomy with intraocular lens implant.
4. Other vision care services, including but not limited to: visual analysis testing, vision therapy, training related to muscular imbalance of the eye, or eye exercises.

8. EXCLUSIONS

The following services and benefits are excluded under this Certificate of Coverage:

1. Services not provided, ordered or referred by the Primary Care Physician (except as described in this section for Emergency Services, well-woman exams, annual diabetic retinal eye exam, annual well man exam, routine vision exam, and the prospective parent Primary Care Physician visit).

2. Services of Non-Contracting Providers, except for Emergency Services or when authorized by the Member's Primary Care Physician and prior authorized by PPK.

3. Any services which are not Medically Necessary.

4. Care for health conditions required by state or local law to be treated in a public Facility.

5. Experimental or Investigational treatments, procedures, or devices and related services unless otherwise described in this Certificate.

6. Unproven or obsolete treatments, procedures or devices and related services, unless otherwise described in this Certificate.

7. Transplants except as described in this Certificate.

8. Cosmetic treatment or surgical procedures primarily to restore or alter appearance unless specified in the Reconstructive Treatment/Surgery benefit section of this Certificate.

9. Cost associated with smoking cessation programs.

10. Cost associated with commercial pain management programs.

11. Vitamins, minerals, nutritional supplements, or special diet foods whether or not required by a Physician.

12. Cosmetic, health, and beauty aids.

13. Treatment of teeth or structures directly supporting the teeth including, but not limited to, extraction of teeth (including bony impacted wisdom teeth), routine cleaning, dental examination, x-rays, and repairs, fillings, scaling, scraping and/or root planing, dentures, bridges, dental implants, casts, and splints, straightening of teeth, services for dental malocclusion, maxillofacial orthognathic and prognathic treatment/surgery, orthodontics, periodontics, or hospitalizations for Non-Covered Services, except as specified in the Oral Surgery and Related Benefits and the Transplant benefit sections of this Certificate.

14. Services or supplies related to intersex surgeries.

15. Non-medical ancillary services including, but not limited to, legal services, social rehabilitation, vocational rehabilitation, work reintegration training, work hardening or conditioning, behavioral training, sleep therapy, employment counseling, and educational testing, training, or therapy, unless prior authorized by PPK as part of treatment for traumatic head injury or stroke, or as specified in the Diabetic Services or Maternity Care Services sections.

16. Items of wearing apparel including, but not limited to, orthopedic shoes, unless otherwise described in this Certificate.

17. All charges for or related to autopsies, except when requested by PPK.

18. All charges related to complementary or alternative medicine including, but not limited to, music therapy, guided imagery, therapeutic touch, aroma therapy, acupressure, reflexology, craniosacral therapy, acupuncture, hydro-massage, Vax-D, and sensory integrative techniques and therapy for the development of cognitive skills to improve attention, memory or problem solving, including compensatory training.

19. All prescription drugs, non-prescription drugs and Investigational and Experimental drugs, except as described as covered in this Certificate.

20. Routine foot care including the paring and removing of corns and calluses or trimming of nails unless Medically Necessary for the treatment of a person who, due to a demonstrated medical condition, is unable to perform such activity.

21. Cost of biologicals that are immunizations or medications to protect against occupational hazards and risks.

22. Services for injuries or diseases related to your employment to the extent you are covered or are required to be covered by the workers' compensation law. If the Member enters into a settlement giving up rights to recover past or future medical benefits under workers' compensation law, PPK will not pay past or future medical benefits that are subject of or related to that settlement. In addition, if the Member is covered by a workers' compensation program, which limits benefits other than specified by the program, PPK will not pay balances of charges from such non-specified Providers.

23. Benefits of this Certificate will not duplicate benefits provided under Federal, State or local laws, regulations or programs. Examples of such programs are: Medicare, Tricare and services in any veteran's Facility when the services are eligible for coverage by the government. This Certificate will provide coverage on a primary or secondary basis as required by state or federal law. This exclusion does not apply to Medicaid. This exclusion applies whether or not you choose to waive your rights to these services.
24. Services related to the treatment of temporomandibular joint disease (TMJ) and Myofascial Pain Dysfunction Syndrome (MPDS).

25. Whole blood, and blood plasma or payments to donors for blood or payment to a blood collection site.

26. Transportation, food, and lodging unless otherwise described in this Certificate

27. The costs of health services resulting from accidental bodily injuries arising from or out of the ownership, operation, maintenance, or use of a motor vehicle to the extent such services are required to be covered by motor vehicle financial responsibility laws, regulations, or programs, or are payable under any medical expense payment provisions (by whatever terminology used-including such benefits mandated by law) of any automobile insurance policy.

28. Services performed by the Member or their parent, spouse, sibling or child.

29. Injuries incurred while the Member is in the commission or attempted commission of a felony.

30. Services resulting from war or an act of war.

31. Services or items for the convenience of the Member or Provider including, but not limited to, home laboratory testing and duplication of covered durable medical equipment.

32. Services when the Member is not present including, but not limited to, case management team conferences, telephone calls, electronic communication, telemedicine, and consultations with family members.

33. Any service(s) rendered where the Member(s) receives monetary or in-kind enticement, incentive, rebate or kickback of any kind from a Provider(s) or agent(s) of a Provider(s).

34. Any service(s) rendered and/or billed by a Provider through misrepresentation of material fact or fraud.

35. Items not strictly for the purposes of treating a medical condition including, but not limited to, over the counter batteries, massagers, air/water purifiers, air conditioners, pillows, mattresses, communication devices/aids, whirlpools, bedwetting alarms, prenatal cradles, breast pumps, car seats, strollers, shower chairs, commodes, thermal therapy devices, or modifications to the Member's home or vehicle.

36. Treatment for physiological impotence will be limited to an implant of a penile prosthesis and other accepted medical treatment as prior authorized by PPK.

37. Any portion of a Claim that PPK determines to be incorrectly or inappropriately billed by a Physician, Health Professional, Facility or Hospital. This includes, but is not limited to: unbundling of procedural services, office visits that take place within a global period, and inappropriate modifier use.

38. Chelation therapy, except for acute arsenic, gold, mercury or lead poisoning.

39. Evaluations and diagnostic tests ordered or requested in connection with criminal actions, divorce, child custody, or child visitation proceedings and any assessment against any person required by a diversion agreement or by order of a court to attend an alcohol and drug safety action program certified pursuant to K.S.A. 8-1008 and amendments thereto.

40. Medical and surgical treatment and all services related to such treatment of obesity (including morbid obesity) and weight reduction. Any medical services rendered in conjunction with prescription drug therapy for weight control. Such services include prescriptions, hospitalizations, laboratory, and x-ray services, and Physician office visits. Membership costs or fees associated with health clubs, exercise programs, and weight loss programs.

Exhibit A: Prior Authorization List

PPK requires Prior Authorization for the following Health Care Services:

- Clinical trials/Experimental services;
- Durable medical equipment;
- Epidural pain blocks;
- Inpatient hospitalizations for medical conditions, rehabilitation, hospice, and skilled nursing care;
- Intravenous and injectable medications (given in the home);
- Non-Contracting Providers;
- Out of area care;
- Outpatient rehabilitation services;
- Outpatient surgical procedures;
- PET scans;
- Prosthetics;
- Transplant evaluation and all other related services including outpatient bone marrow transplants; and
- Tube feeding solutions.

PPK recommends Prior Authorization of the following Health Care Services as they may not be covered benefits:

- Breast implant/reduction/reconstruction;
- Breast surgery for males;
- Cosmetic surgeries (including, but not limited to, eyelids, nose, sagging skin, liposuction);
- Dental and oral surgery services;
- Infertility services (including, but not limited to, laparoscopic surgery of pelvis, hysteroscopy, sperm counts and analysis, and hysterosalpingogram); and
- Varicose vein surgery/sclerotherapy.

Behavioral Health

The Member is responsible for contacting PPK for Prior Authorization of inpatient and outpatient behavioral health and substance abuse. Prior Authorization may be obtained by calling 316-609-2541 or 1-866-338-4281 (outside Wichita), Monday-Friday, 8a.m.-5p.m. Staff is available after hours and on weekends and holidays to assist Members with urgent situations.

This Prior Authorization List is subject to change. An up-to-date Prior Authorization List can be found at www.phsystems.com or by calling Member Services at 316-609-2390 or 1-800-660-8114 (outside Wichita).

PREFERRED PLUS OF KANSAS, INC.
STATE OF KANSAS
SCHEDULE OF BENEFITS
2007

Benefit Period: Benefits accumulate from January 1 to December 31

Preferred Health Systems is offering a HMO benefit plan through Preferred Plus of Kansas (PPK). To enroll for coverage in PPK, Employees and all covered Dependents must select a Primary Care Physician (PCP). When you or your Dependents are in need of health care, services must be provided or referred in advance by your PCP or prior authorized by PPK. Services which are not provided or referred by your PCP or prior authorized by PPK are not covered.

BENEFIT CATEGORY	MEMBER RESPONSIBILITY
PCP OFFICE VISIT	$20 Copayment
SPECIALIST PHYSICIAN VISIT	$30 Copayment
COINSURANCE	Applies to all Covered Services unless otherwise noted Subject to 10% Coinsurance See Definition section of the Certificate for explanation of Allowed Amounts
OUT OF POCKET COINSURANCE MAXIMUM	Individual $1,000 Family $2,000 After the out-of-pocket Coinsurance maximum has been reached, benefits will increase to 100% of the Allowed Amounts for the remainder of the Benefit Period. The following do not count towards meeting the out-of-pocket Coinsurance maximum: Copayments or outpatient behavioral health and substance abuse (BH/SA).
LIFETIME MAXIMUM	$3,000,000 The lifetime maximum will include benefits you have accumulated under another PPK health plan offered by the same employer prior to this coverage.

PREVENTIVE SERVICES - Coverage will be provided for the following services once annually unless otherwise indicated:

Well baby and well child care exams† as age appropriate when provided by the Member's PCP	$20 PCP Copayment
Routine childhood immunizations up to seventy-two (72) months of age	No Coinsurance or Copayment unless billed with an office visit
Routine immunizations for Members over seventy-two (72) months of age	Subject to Coinsurance and Copayment if billed with an office visit
Routine physical exam† when provided by the Member's PCP	$20 PCP Copayment
General health lab panel and/or lipid panel screening	No Copayment or Coinsurance
Comprehensive metabolic panel screening	No Copayment or Coinsurance
Cholesterol and/or triglyceride screening	No Copayment or Coinsurance
Complete blood count screening	No Copayment or Coinsurance
Creatinine screening	No Copayment or Coinsurance
Thyroid stimulating hormone (TSH) screening	No Copayment or Coinsurance
Screening urinalysis	No Copayment or Coinsurance
One routine age appropriate colonoscopy per lifetime	No Copayment or Coinsurance; then subject to Copayment and Coinsurance
Digital rectal exam	No Copayment or Coinsurance
Fecal occult blood screening	No Copayment or Coinsurance
Routine well woman exam†	$20 PCP or $30 contracting OB/GYN Copayment (no referral required)
Routine mammogram	No Copayment or Coinsurance
Routine Pap test	No Copayment or Coinsurance
Screening vaginal culture/smear	No Copayment or Coinsurance
Screening urinalysis	No Copayment or Coinsurance
Bone density screening	No Copayment or Coinsurance
Routine well man exam†	$20 PCP or $30 contracting urologist Copayment (no referral required)
Screening PSA exam	No Copayment or Coinsurance
Routine hearing exam	No Copayment or Coinsurance
Routine eye exam and refraction when provided by a Contracting Provider (no referral required)	No Copayment or Coinsurance
Dietitian consultations	$30 specialist Copayment

Any follow-up services and/or additional visits require a referral authorization from the Member's PCP.
Coinsurance applies to all testing provided in conjunction with preventive services when billed with an established diagnosis.

†Applicable Copayment will be waived for one (1) routine physical examination per Member, per Benefit Period.

OUTPATIENT LAB, X-RAY, AND MINOR DIAGNOSTIC TESTING	Subject to Coinsurance

MAJOR DIAGNOSTIC TESTING	$100 Copayment; then subject to Coinsurance Includes, but is not limited to: PET scans*, Heart Catheterizations, Sleep Studies, MRI, CT, Nuclear Cardiology Studies, Magnetic Resonance, Angiography, and Computerized Topography
INPATIENT BENEFITS* (Semi-Private Room, ICU, SNU, Hospice)	$200 Copayment per admission; then subject to Coinsurance
MATERNITY CARE Prenatal and Postpartum Services Inpatient Services*	Services must be rendered by your PCP or contracting OB/GYN $20 PCP or $30 specialist Copayment Subject to inpatient benefits
OUTPATIENT SURGERY* (including office procedures)	$100 Copayment; then subject to Coinsurance
ALLERGY TESTING OR TREATMENT	Subject to Coinsurance
INPATIENT BEHAVIORAL HEALTH AND SUBSTANCE ABUSE*	Subject to inpatient benefits Services must be prior authorized by PPK by calling 316-609-2541 or 1-866-338-4281 (outside Wichita). Maximum benefit limited to sixty (60) days per Member, per Benefit Period. Each partial day session will count as one half inpatient day toward the sixty (60) day benefit.
INPATIENT BIOLOGICALLY BASED MENTAL ILLNESS*	Subject to inpatient benefits
OUTPATIENT BEHAVIORAL HEALTH AND SUBSTANCE ABUSE*	100% of Allowed Amounts of the first three (3), the next twenty-two (22) visits require $25 Copayment; then 50% of Allowed Amounts, per Member, per Benefit Period. Group therapy will count as 1/2 of a visit. Services must be prior authorized by PPK by calling 316-609-2541 or 1-866-338-4281 (outside Wichita).
OUTPATIENT BIOLOGICALLY BASED MENTAL ILLNESS	Subject to Applicable PCP or specialist Physician Copayments
EMERGENCY SERVICES IN THE SERVICE AREA ***There is no coverage for non Emergency Medical Conditions treated in a Hospital emergency room.***	$75 Hospital emergency room Copayment, then subject to Coinsurance $30 urgent care facility Copayment If admitted, Copayment will be waived and inpatient benefits will apply. If you receive Emergency Services from a non-contracting Hospital within the Service Area such services will only be covered in situations where you had no control over when and where such services were rendered.
EMERGENCY SERVICES OUT OF THE SERVICE AREA (if Emergency Medical Condition)	$75 Hospital emergency room Copayment, then subject to Coinsurance $30 urgent care facility Copayment If admitted, Copayment will be waived and inpatient benefits will apply.
AMBULANCE	Subject to Coinsurance
DURABLE MEDICAL EQUIPMENT* AND DISPOSABLE MEDICAL SUPPLIES	Subject to Coinsurance Maximum benefit limited to $5,000 of Allowed Amounts, per Member, per Benefit Period Disposable medical supplies include: - Ostomy (appliance pouches, skin care agents, support belts) - Open wound (gauze pads, wound packing strips, ABD pads) - Venous access catheter (alcohol pads, benzoin, dressings) - Urinary supplies (catheter and bag supplies) - Tracheostomy supplies - Inhaler supplies (aero chamber mask, spacers, peak flow meters) - Compression gloves and sleeves; - Compression stockings; and - Mastectomy supplies.
DIABETIC EQUIPMENT AND SUPPLIES	Subject to Coinsurance Must be purchased from Contracting Providers and referred by your PCP.
RECONSTRUCTIVE SURGERY FOLLOWING A MASTECTOMY	Subject to Applicable Coinsurance or Copayments Coverage will be provided in a manner determined in consultation with the treating Physician and the Member for reconstruction of the breast on which the mastectomy has been performed; surgery and reconstruction of the other breast to produce symmetrical appearance; prostheses and physical complications during all stages of the mastectomy, including lymphedema.
HOME HEALTH CARE	Subject to Coinsurance Maximum benefit limited to $5,000 of Allowed Amounts per Member, per Benefit Period.
INTRAVENOUS (IV) AND INJECTABLE MEDICATIONS*	Subject to Coinsurance Prior Authorization is required if given in the home
OUTPATIENT HOSPICE SERVICES	Subject to Coinsurance Maximum benefit limited to $7,500 of Allowed Amounts per Member, per lifetime.

REHABILITATION SERVICES* (physical, speech, and occupational therapies; cardiac rehabilitation; and spinal manipulation services)	***Facility based inpatient and outpatient services*** are covered if medically necessary and only if significant improvement is shown within the first thirty (30) days of treatment. - Inpatient Facility services are subject to a $200 Copayment per admission, then Coinsurance. - Outpatient Facility services are subject to Coinsurance. ***Office based services*** are limited to thirty (30) visits per Member, per Benefit Period. - Office based services are subject to the applicable Copayment and Coinsurance.
ORTHOTICS AND PROSTHETICS*	Subject to Coinsurance Coverage is limited to the original device unless repair and/or replacement is Medically Necessary.
ORAL SURGERY AND RELATED SERVICES	Subject to Coinsurance Coverage is for limited dental services. Refer to your Certificate for details. All claims for treatment of accidental trauma to sound natural teeth are administered through the State's dental plan.
TRANSPLANT SERVICES*	Subject to Applicable Coinsurance or Copayments Members are entitled to receive benefits for human organ and tissue transplant services through Contracting Providers. Transplants covered include: Bone marrow (allogenic or autologous); Cornea; Heart; Heart-Lung; Lung (single or double); Intestine; Liver; Kidney; and Pancreas.

***These services require Prior Authorization by PPK.**

Prior Authorization is the process of PPK determining whether the Health Care Service is a Covered Service, Medically Necessary, and being rendered by Contracting Providers. Coverage is subject to eligibility and benefits remaining at the time services are rendered.

The Prior Authorization List is subject to change. An up-to-date Prior Authorization List can be found at www.phsystems.com or by calling Member Services at 316-609-2390 or 1-800-660-8114 (outside Wichita).

Referral Process: PPK Members are responsible for obtaining a Referral Authorization from their PCP for all Health Care Services (except Emergency Services, annual well-woman exam, annual well-man exam, annual diabetic retinal eye exam, and prospective parent PCP visit) rendered outside his/her office. Behavioral health and substance abuse services do not require a PCP Referral Authorization; however, they must be Prior Authorized by PPK.

Please consult your Certificate for complete plan provisions, limitations, and exclusions.